



# Arizona Arthritis & Rheumatology Associates, P.C.

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## Patient History

### PATIENT INFORMATION

<b>PATIENT NAME</b>		<b>TODAYS DATE</b>	
<b>HEIGHT (in)</b>	<b>WEIGHT (lbs)</b>	<b>DATE OF BIRTH</b>	<b>SEX</b> <input type="checkbox"/> Female <input type="checkbox"/> Male
<b>MENOPAUSE AGE</b>	<b>ETHNICITY</b>		

	YES	NO
1. Have you had a previous hip or vertebral fracture?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you had any fractures during your adult life which did not result from significant trauma (e.g., auto accident)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Did either of your parents ever have a hip fracture?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever taken Glucocorticoids (Prednisone, cortisone) for more than 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have rheumatoid arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you drink 3 or more alcoholic drinks per day?	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you being treated for osteoporosis?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever taken any of the following medications?		
<input type="checkbox"/> Actonel (i.e. risedronate) <input type="checkbox"/> Boniva (i.e. ibandronate) <input type="checkbox"/> Evista (i.e. raloxifene) <input type="checkbox"/> Forteo (i.e. parathyroid hormone)		
<input type="checkbox"/> Fosamax (i.e. alendronate) <input type="checkbox"/> HRT (i.e. estrogen/hormone therapy) <input type="checkbox"/> Miacalcin (i.e. calcitonin)		
<input type="checkbox"/> Protelos (i.e. strontium ranelate) <input type="checkbox"/> Reclast (i.e. zoledronate) <input type="checkbox"/> Prolia (i.e. denosumab) <input type="checkbox"/> Vitamin D <input type="checkbox"/> Calcium		
<input type="checkbox"/> Other (please specify)		
10. Do you have any of the following medical conditions?		
<input type="checkbox"/> Anorexia or Bulimia <input type="checkbox"/> Any Seizure Disorders <input type="checkbox"/> Asthma or Emphysema <input type="checkbox"/> Cancer <input type="checkbox"/> End Stage Renal Disease		
<input type="checkbox"/> Inflammatory Bowel Disease <input type="checkbox"/> Hyperparathyroidism <input type="checkbox"/> Hysterectomy		
<input type="checkbox"/> Other (please specify)		
11. What was your maximum height (in)?		
	YES	NO
12. Do you perform weight bearing exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you regularly consume dairy products?	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you drink caffeinated beverages?	<input type="checkbox"/>	<input type="checkbox"/>
15. Are you pre-menopausal?	<input type="checkbox"/>	<input type="checkbox"/>